NEW HAVEN LEGAL ASSISTANCE ASSOCIATION, INC.
426 STATE STREET
NEW HAVEN, CONNECTICUT 06510-2018
TELEPHONE: (203) 946-4811
FAX (203) 498-9271

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Testimony of Sheldon Toubman in Support of HB 5450 (Establishing a Basic Health Program for Low-Income Connecticut Residents up to 200% of the Federal Poverty Level)

Good afternoon, Rep. Tercyak, Senator Musto and members of the Human Services Committee. I am a staff attorney with New Haven Legal Assistance and I am here to testify strongly in support of HB 5450, which would establish a Basic Health Program ("BHP") for Connecticut residents between 133 and 200% of the federal poverty level, as provided as an option for all states under the Patient Protection and Affordable Care Act ("PPACA"), and require that that program be administered as a Medicaid-like program.

Without a BHP, individuals over 133% of the federal poverty level would be required to get insurance from a private risk-based insurer through the Health Insurance Exchange. Unfortunately, all estimates indicate that, for individuals between this income level and 200% of the federal poverty level, even with the substantial federal tax subsidies, this coverage will be unaffordable for many. A BHP as under HB 5450 will provide alternative insurance which is affordable for all of these individuals, and which is as similar to Medicaid as possible.

The substantial benefits of a Medicaid-like BHP, particularly when administered along-side Medicaid, with low overhead, efficiencies of scale, and joint administration through the same non-risk administrative services organization (ASO), cannot be overstated. In a recent January 19, 2012 report to the Board of the Health Insurance Exchange, the consultant Mercer, Inc. noted that "building a BHP on a state's Medicaid infrastructure would allow states to cover low-income parents and children together in the same or similar plans and by the same provider networks." (page 175).

A Medicaid-like system with the same benefits and cost-sharing protections as Medicaid also is financially feasible in Connecticut, without any need for additional state dollars beyond what it will be receiving from the federal government: 95% of saved tax subsidy payments which would otherwise be made for these individuals in the health insurance exchange. Mercer concluded that "**under any scenario** based on the estimated subsidy and costs modeled in this analysis, the result is that **it would be financially feasible for Connecticut to offer a BHP option at Medicaid provider reimbursement levels with no costs to the State.**" (page 188)(emphasis added).

Recognizing that seemingly modest cost-sharing still would cause many at the 133 to 200% of poverty income levels to opt not to participate in the BHP, Mercer modeled cost-sharing to match Medicaid in Connecticut, i.e., no premiums and no cost-sharing. Even for this scenario, Mercer concluded that it would cost 7% less for Connecticut to run a BHP program compared to how much it would be paid by the federal government for creating the BHP (based on 95% of the avoided tax subsidies for the exchange. (page 187). So, based on Mercer's conservative analysis, there will be enough money available for Connecticut to provide Medicaid-like benefits under a BHP without any need for additional state funding. Beyond this, Mercer concluded:

> "**This [no cost-sharing] Medicaid scenario provides the *best advantage to this low-income population, which would also have the best chance of maximizing enrollment.*** This scenario would both cover the greatest number of adults [since the higher cost-sharing would otherwise cause many to opt out] and result in the lowest morbidity level of the risk pool [since healthy young people would by and large participate]." (page 187)(emphasis added).

Mercer clearly found a no cost-sharing BHP to be a realistic alternative. In reaching its conclusions, however, Mercer **substantially underestimated** the savings from a BHP over (95% of) federal subsidies for enrollment with the exchange, in three important ways.

First, it assumed that the administrative cost for providing Medicaid-like services to the BHP group would be "15% (including profit, risk, contingency loading)" (pages 184, 185). But the total administrative costs for administering Medicaid on a non-risk basis are more like **8%**, not 15%.

Second, placing all Medicaid and BHP enrollees under one efficient administrative system, presumably through all the same ASOs, will avoid the administrative costs of someone around 133% of poverty churning between different systems and different sets of providers as their income fluctuates. Beyond this, just having everyone in one system will bring economies of scale, further driving down administrative costs.

Third, in moving to the ASO model for the Medicaid/HUSKY B population in January of this year, the Malloy Administration made clear that it assumes substantial savings from finally coordinating health care in a way that the risk-based MCOs always promised but rarely delivered on. Specifically, through the adoption of patient-centered medical homes which are paid modestly to coordinate all health care for their patients, a lot of unnecessary diagnosis and treatment, resulting from duplicative services or medical complications from conditions untreated at an earlier stage, can be avoided.

For all of these reasons, the 7% margin for the state taking on a BHP with no cost-sharing for BHP enrollees identified by Mercer is quite a conservative estimate. The margin is likely much larger than that, sufficient to finance not only no cost-sharing but truly Medicaid-like

benefits and services, so that health care delivery for individuals going above and below 133% of poverty will be seamless, as it will be for children and adults over 133% and below 200% in the same family.

The other advantages of a Medicaid-like BHP run through the same non-risk ASO system, and with the same network of providers, include:

- Protecting individuals with incomes fluctuating above and below 133% of poverty from disruptions in care and provider networks
- Protecting enrollees from overpayments of tax subsidies in the exchange, resulting from income fluctuations, and the consequent need to pay the money back at a time when they may be unable to do so
- Protecting this relatively low-income population from having services denied by a for-profit plan with a direct incentive to deny care, as under the exchange (this was a serious problem for Medicaid enrollees under the MCO system, one of the reasons we just moved out of that system)
- Providing meaningful care management services through patient-centered medical homes (which also should serve to drive down costs)

Finally, under the PPACA, any savings beyond what it costs to run the BHP must be plowed back into the program to improve it by expanding benefits or increasing provider rates. Given the concerns with provider access under Medicaid in part due to low reimbursement rates for some categories of providers, it will be important to prioritize provider rates with any excess savings. However, even if provider rates in the BHP are not increased over Medicaid rates (which, under the PPACA, must be increased to Medicare rates during 2013-2014 for primary care), the BHP population will be better served with a BHP with affordable care than through an unaffordable plan obtainable only through a risk-based Exchange insurer. According to Mercer, **50%** of the same population would forego participation in the Exchange due to this unaffordability (page 192), meaning that, for half of the population, the provider reimbursements would not be low; they would be non-existent.

In sum, the BHP option is not only far better a means of reducing the rolls of the uninsured, and at no additional cost to the state; it also is the best way of addressing the lack of payments for the providers of such low-income individuals. While it would be helpful to amend the bill to explicitly provide that the BHP must be administered through the same ASO as administers Medicaid, and using the same provider network and delivery model, in order to ensure maximum efficiency, this is a very good bill. I urge you to pass favorably on it, so that the state can begin to design a plan that will efficiently provide quality, affordable care for all non-elderly individuals up to 200% of the poverty level, through a unitary non-risk system.

Thank you for allowing me to speak before you today.